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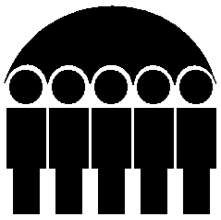
Employees' Manual
Title 13
Chapter H

TARGETED CASE MANAGEMENT SERVICES



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CHAPTER OVERVIEW

Targeted case management services were developed as a result of 1988 Iowa Acts, Chapters 1245 and 1276. This legislation mandates that the Department of Human Services must provide individual targeted case management services:

- If designated by a county board of supervisors or a cluster of counties.
- In the event that a county board chooses not to designate any provider.

Targeted case management is a service designed to help consumers with mental retardation, chronic mental illness or developmental disabilities gain access to appropriate living environments, needed medical services, and interrelated social, vocational, and educational services. Targeted case management services are provided to consumers who meet two criteria.

- The consumer must have a diagnosis of:
  - Mental retardation.
  - Developmental disabilities.
  - Chronic mental illness.
- The consumer must be eligible for:
  - Medicaid.
  - 100 percent funding from the county of legal settlement.
  - An alternate funding source.

The service is designed to enhance the capacities of consumers and their families or guardians to exercise their rights and responsibilities as citizens in the community. The goal is to enhance consumers' abilities to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community. State standards and principles encourage the use of services and activities that are the same as those used by the general population.

These standards and principles also emphasize that the focus of activities within the service system must be on the unique needs of each consumer. All services and living arrangements should encourage the development of each consumer's strengths and potentials to the fullest extent possible.

To ensure that consumers are receiving the services necessary to meet their needs, each consumer is assigned a targeted case manager. The targeted case manager assumes responsibility for using these principles.

Targeted case management focuses on the consumer's strengths, interests, abilities, and competencies. The service involves the consumer, families, guardians, and other professionals and agencies in identifying, developing, implementing and monitoring a comprehensive outcomes achievement plan (OAP). Targeted case management allows the consumer optimal opportunity for:

- Gaining independence.
- Attaining integration into the community.
- Maximizing participation in the decision making process.
- Achieving outcomes.

The targeted case manager directs all case activities with a consumer by coordinating services with other providers. The targeted case manager acts as an advocate to link consumers to service agencies and support systems responsible for providing the necessary direct services. The targeted case manager follows the consumer through the service system to coordinate and monitor these activities and ensure that the consumer's needs are being met in the manner that is planned.

The targeted case manager should develop a relationship with the consumer so the strengths, needs, wants, abilities, and desires of the consumer are clearly identified and communicated. The targeted case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

Interventions respect and enhance a consumer's abilities and dignity, encourage the development of a sense of achievement and allow the consumer to choose to continue or modify the consumer's participation in the treatment process. Targeted case managers should consider language barriers, cultural differences, and cognitive deficits and make provisions to facilitate meaningful consumer participation.

Legal Basis

The statutory basis for the establishment of state standards for a service coordination system and for the provision of individual targeted case management service is Iowa Code Chapter 225C. The Mental Health and Developmental Disabilities Commission of the Department of Human Services promulgates rules setting these standards:

- 441 Iowa Administrative Code, Chapter 23, "Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury Community Services," sets requirements for county governments in planning for targeted case management services and other services.
- 441 Iowa Administrative Code, Chapter 24, "Standards for Providers of Services to Persons with Mental Illness, Mental Retardation, and Developmental Disabilities," Divisions I and II, sets certification standards for targeted case management providers.

1988 Iowa Acts, Chapter 1276, section 14, authorized the addition of targeted case management services to the state Medicaid Plan. Conditions of participation for targeted case management providers under the Medicaid program are found in rule 441 Iowa Administrative Code 77.29(249A). The amount, duration, and scope of targeted case management services covered by Medicaid are defined in rule 441 Iowa Administrative Code 78.33(249A).

General policies regarding providers of medical care and procedures for Medicaid payment are found in 441 Iowa Administrative Code, Chapters 79 and 80. To qualify as a Medicaid provider, targeted case management agencies must be certified by the Mental Health and Developmental Disabilities Commission as meeting the standards noted above.

Chapter Organization

The purpose of this chapter is to provide basic procedures for Department staff to follow in the provision of targeted case management services. This chapter is specific to targeted case management services only. Other portions of the Department Employees' Manual are relevant in performing job responsibilities. The Employees' Manual is cross-referenced to assist workers in locating pertinent policies and procedures.

List of Requirements

Actions	Forms
Take applications	*Application for All Social Services,* SS-1120-0, or county CPC application.
Determine if consumer's diagnosis meets the target population	Verify the consumer's disability and document in the consumer's file
Determine consumer's funding eligibility	Documentation includes: • Copies of IABC or SSNI screens. • Copy of consumer's *Medical Assistance Eligibility Card*, SS-1645, or income maintenance communication. • Written verification of 100% county funding approval or alternate funding availability.
Secure approval for children for HCBS/MR or HCBS/BI services	*Medicaid Home- and Community-Based Services Agreement* (MA-2171) approval from the Division of Medical Services
For medically needy consumers, secure consent	Documentation of medically needy status and written statement that consent was secured
Verify legal settlement of the consumer OR	A letter from the county auditor's office or CPC or other verification of the county's acknowledgment of legal settlement.
Secure approval as a "state case"	*Application for the State Payment Program for Services to Adults,* SS-1106-0 *Service Reporting System,* RS-1120-0
Approving the consumer's application for targeted case management services	*Notice of Decision: Services,* SS-1104-0 *Report for Enhanced Services,* 470-2464 *Service Reporting System,* RS-1120-0
Denying the consumer's application for targeted case management	*Notice of Decision: Services,* SS-1104-0

Complete initial intake	*Assessment Worksheet,* 470-3447 *Assessment Summary*, 470-3446 *Social History*, 470-3661
Conduct the initial interdisciplinary team meeting	Assist consumer in identifying persons to participate in and arrange meeting
Develop the service plan	Complete *Outcomes Achievement Plan,* 470-2560
Arrange funding for all services included in the consumer's plan	Document available funding
Develop crisis intervention plan	Designate individuals, providers, or natural supports to be contacted in case of a consumer emergency
Monitor services specified in the OAP	Narration in the consumer's case file that documents interventions and consumer's response to those interventions
Sign bill for each consumer with a billable contact	*Claim for Targeted Medical Care*, 470-2486
Collect information for and complete quarterly benchmarks	*Service Activities Benchmark,* 470-2561
At least annually, review and summarize the consumer's level of functioning, need for services and need for additional evaluations	*Assessment Summary*, 470-3446 *Social History*, 470-3661 *Assessment Worksheet,* 470-3447
At least annually, revise the OAP, based on results of the *Outcomes Assessment*	*Outcomes Achievement Plan,* 470-2560
Terminate targeted case management services	*Notice of Decision: Services,* SS-1104-0 *Assessment Worksheet,* 470-3447 *Assessment Summary*, 470-3446 *Social History*, 470-3661

ELIGIBILITY

Legal reference: 441 IAC 78.33(249A), 24.2(4) and 83.61(1)

Targeted case management services are provided to Medicaid-eligible consumers by the Department targeted case management unit best able to meet the consumer's particular needs. Targeted case management services to non-Medicaid eligible consumers are provided by the Department targeted case management unit serving the consumer's county of legal settlement based on the criteria in the contract with the county

Eligibility policies and procedures are organized in the following sections:

- Application.
- Determining eligibility:
  - Target population.
  - Need for targeted case management services.
  - Eligibility for funding.
- Approving or denying applications:
  - Approving applications using the referral list.
  - Denying applications.

Application

Legal reference: 441 IAC 130.2(234)

Persons requesting targeted case management services shall apply using either:

- Central point of coordination (CPC) application from the consumer's county of legal settlement, when applying for both county-funded services and targeted case management at the same time.
- Form SS-1120-0, *Application for All Social Services,* for children, applicants with state case status, private pay applicants, and consumers who already have a CPC application on file with the county (i.e., when the referral is from the CPC).

A new *Application for All Social Services,* SS-1120-0, is not needed if the person requesting waiver services is currently receiving services. Form SS-1645, *Home- and Community-Based Service Report,* from Income Maintenance staff shall be the notice that a consumer has applied for HCBS MR or HCBS BI waiver services.

Accept applications for targeted case management services at the office where the consumer requests service. Staff may provide information about Medicaid eligibility to persons requesting targeted case management services before an application is completed. (See **Determining Eligibility**.)

When you receive an application for a consumer who is not a Medicaid recipient, refer the applicant to the IM worker in the county of residence to determine the consumer's eligibility for Medicaid. If the consumer is eligible for Medicaid, request eligibility verification from the IM worker.

If a you receive an application from a consumer with a guardian, verify that the guardian has signed the application.

If you receive a request for services from a consumer who does not fall within the responsibility of the Department's targeted case management unit, inform the consumer that the county of legal settlement has designated another provider to provide targeted case management services. Provide the name and telephone number of the designated provider to the consumer.

If you receive a request for service from a consumer residing outside the consumer's county of legal settlement, and the consumer's county of legal settlement has designated the Department as the targeted case management provider, initiate eligibility determination.

The lead supervisor of the office accepting the application from the consumer shall discuss the case with the lead supervisor of the other office that might be expected to serve the consumer. The two supervisors shall decide which office can most appropriately provide targeted case management services to the consumer. Factors to consider may include, but are not limited to:

- The goals of the consumer, especially in regard to residence and service needs.
- The length of time a consumer is expected to remain in a placement and the immediacy of transfer.
- The community that the consumer considers "home."
- The distance between the consumer and the targeted case manager and any potential impact on the provision of services.
- The wishes and involvement of the family or other's significant in the consumer's life.
- The available slots in targeted case manager caseloads in both units.

Discuss special circumstances affecting a consumer requesting targeted case management service with the unit administrator or designee before processing an application.

Notify the CPC if the consumer is approved for targeted case management services.

Determining Eligibility

Legal reference: 441 IAC 78.33(249A) and 24.2(4)

To be eligible for targeted case management services, a person must:

- Have a primary diagnosis of mental retardation, a developmental disability, or chronic mental illness.
- Have a need for targeted case management services.
- Be eligible for Medicaid or an alternate funding source.

Target Population

Legal reference: 441 IAC 24.1(225C)

For the purposes of targeted case management, the definitions of the target populations are as follows:

- **"Mental retardation"** means a diagnosis of mental retardation made only when the onset of the person's condition was before the age of 18 years and based on an assessment of the person's intellectual functioning and level of adaptive skills.

  A diagnosis of mental retardation must be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

  The diagnosis must be made by a person who is a psychologist or psychiatrist and is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills.

- **"Persons with a chronic mental illness"** means people aged 18 and over who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. People with chronic mental illness typically meet at least one of the following criteria:

- They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization).
- They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, these people typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years:

- They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- They require services to live in the community.
- They show severe inability to establish or maintain a personal social support system.
- They require help in basic living skills.
- They exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness.

Exception: For purposes of targeted case management, people with mental disorders resulting from Alzheimer's disease or substance abuse are not considered chronically mentally ill.

♦ **"Persons with developmental disabilities"** means people who have a severe, chronic disability which:

- Is attributable to mental or physical impairment or a combination of mental and physical impairments.
- Is manifested before the person attains the age of 22.
- Is likely to continue indefinitely.
- Results in substantial functional limitation in three or more of the following areas of life activity: self–care, receptive and expressive language, learning, mobility, self–direction, capacity for independent living, and economic self–sufficiency.

This term is also applied to infants and young children from birth through the age of five who have:

- Substantial developmental delay.
- Specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

Need for Targeted Case Management Services

Evidence of the need for targeted case management services is based on information provided by the consumer and from diagnostic reports. Consumers may need the assistance of a targeted case manager to:

- Provide service coordination.
- Advocate for and protect consumer rights.
- Provide support for consumers.
- Provide problem-solving assistance and instruction.
- Facilitate independent consumer decision making.
- Provide assistance in locating, accessing, and securing funding for services.
- Facilitate changes in interventions, both in placement and programming.
- Monitor service provision.
- Prevent the need for frequent crisis intervention.
- Prevent regression to more restrictive interventions.

Eligibility for Funding

Legal reference: Iowa Code Section 225C.20, 441 IAC 78.33(249A)

Verify that the person applying for targeted case management services has been determined eligible for Medicaid or alternate funding. Secure verification that the applicant has been approved as one of the following:

- A Medicaid-eligible person with mental retardation, developmental disabilities or chronic mental illness who does not reside in a medical institution or is within 30 days of discharge from a medical institution and whose basis of eligibility is not QMB (qualified Medicare beneficiary).
- A Medicaid-eligible child or adult approved for HCBS MR waiver services who meets the definition of a person with mental retardation and has been certified by the Iowa Foundation for Medical Care as needing the ICF/MR level of care. (See 16-K(4), **ELIGIBILITY CRITERIA**.)

- A Medicaid-eligible person with mental retardation, developmental disabilities, or chronic mental illness whose Medicaid eligibility is conditionally established through the medically needy program, when the person's spenddown does not exceed twice the monthly cost of targeted case management services.
- A person with mental retardation, a developmental disability, or chronic mental illness who has legal settlement in a county contracting with the Unit to serve non-Medicaid eligible persons and who meets the eligibility criteria specified in the contract.
- A person with mental retardation, a developmental disability, or chronic mental illness who agrees to prepay the full monthly cost of targeted case management services from personal funds. A consumer using personal funds for the full cost of targeted case management must complete a private-pay agreement before service is initiated.
- A child with mental retardation waiting approval for HCBS/MR waiver approval eligible for decategorization funding contracted with the local DHS Decategorization Project.

Targeted case management services cannot be reimbursed unless the consumer belongs to one of these groups. Verification includes:

- Medicaid Assistance Eligibility Cards.
- Medically Needy Notices of Decision.
- Iowa Automated Benefit Calculation (IABC) System screen prints.
- A private-pay agreement.
- An approval letter from the funder.

Assessment of the eligibility and need for targeted case management services are reimbursable:

- Through Medicaid, if the consumer is Medicaid-eligible.
- Through the county for non-Medicaid-eligible consumers served through a contract.

Approving or Denying Applications

Legal reference: 441 IAC 24.2(4) and 130.2(234)

Approve or deny the application for targeted case management services no later than 30 days after receipt of the application.

Notify the applicant or the applicant's legally authorized representative of approval using *Notice of Decision: Services,* form SS-1104-0, when you have determined that the consumer:

- Has a diagnosis in one of the three target population groups.
- Is Medicaid-eligible.
- Has legal settlement in a county served by the unit.

Complete the *Report For Enhanced Services*, form 470-2464, to ensure that the county of legal settlement and the diagnosis are entered onto the Medicaid eligibility file (IABC). For consumers with eligibility through the Medically Needy program:

- Secure verification of conditional eligibility before initiating services and at the beginning of each certification period.
- Secure acknowledgment from the consumer that the consumer understands the spenddown must be paid within 30 days of the date on the second invoice or targeted case management services will be terminated.

Notify a non-Medicaid eligible consumer of approval for 100% county funding for targeted case management services using the county's prescribed method of notification when you have determined that the consumer has:

- A diagnosis in one of the three target populations.
- Legal settlement in a county contracting with the Unit for targeted case management services to non-Medicaid eligible persons.

Send a copy of the 100% County-Funded Contract to the targeted case management accounting technician.

The following sections explain procedures for:

- Approving applications using the referral list.
- Denying applications.

Approving Applications Using the Referral List

When targeted case management services cannot begin immediately for a Medicaid-eligible consumer because there is no opening on a caseload, approve the application and put the consumer on the referral list for assignment to a targeted case manager. Complete the *Report For Enhanced Services*, form 470-2764, to ensure that the county of legal settlement and diagnosis are entered onto the Medicaid eligibility file.

Notify the applicant or the applicant's legally authorized representative of approval and placement on the referral list using *Notice of Decision: Services*, form SS-1104-0.

Notify the applicant or the applicant's legally authorized representative of the date the consumer has been assigned to a targeted case manager for initiation of targeted case management services using a second *Notice of Decision: Services*, form SS-1104-0.

The applicant cannot be on a referral list for more than 90 days. Also, if more than 20 consumers are on a referral list at the same time, this is considered a denial of service.

Denying Applications

Legal reference: 441 IAC 130.5(1)

Deny applications for Medicaid-funded targeted case management services when:

- The applicant is not currently Medicaid-eligible.
- The applicant does not meet the definition of the target population.
- The applicant or the applicant's legally authorized representative withdraws the application.
- The applicant does not provide information required to process the application.
- The applicant is receiving targeted case management services from another Medicaid provider.
- The applicant does not have any current targeted case management needs identified during the initial intake or subsequent evaluation.

Deny an application for non-Medicaid-funded targeted case management services when:

- The applicant does not meet the definition of the target population.
- The applicant does not meet the criteria set by the county of legal settlement.
- The contract with the applicant's county of legal settlement is terminated.
- The applicant is receiving targeted case management services from another provider.

When denying an application for targeted case management services:

- Notify the applicant or the applicant's legally authorized representative that the application for targeted case management was denied, specifying the reason for the denial, using *Notice of Decision: Services,* form SS-1104-0.
- Refer the applicant to the Department's service unit, if other services are needed or requested.
- Prepare documentation for the case record which includes:
  - The consumer's name.
  - The nature of the request for services.
  - A summary of any evaluation activities completed.
  - The reason for the denial.
  - A summary of any referrals made.

  Retain this documentation for at least three years.

SERVICE DELIVERY

Legal reference: 441 IAC 24.1(225C) through 24.7(225C)

Targeted case management services are not direct services. The services are composed of the following:

- Gathering sufficient information to identify all areas of need for services and appropriate living arrangements.
- Developing and completing an *Outcomes Achievement Plan* (OAP) based on findings included in the *Assessment Summary* and the *Social History*, addressing the person's total needs for services and living arrangement.
- Assisting the consumer to obtain the services and living arrangements identified in the OAP.

- Coordinating and facilitating decision making among providers so there is consistency in the implementation of the OAP.
- Monitoring the services and living arrangements to ensure continued appropriateness for the consumers.
- Facilitating the development of an individualized crisis intervention plan that identifies potential emergencies and how to access emergency services and supports, when needed.

Service delivery policies and procedures are arranged in the following sections:

- Service delivery principles.
- Protection of consumers' right.
- Intake and evaluation.
- Service planning.
- Termination of services.

Service Delivery Principles

Legal reference: 441 IAC 22.2(225C) and 24.2(11)

Deliver services in accordance with the following principles:

- Services and settings used by consumers must facilitate physical and social integration with the general society. Factors that may facilitate integration include, but need not be limited to, access to, use of, and interaction with community professional, social, and recreational resources, businesses, and public services.
- Services and settings must promote personal appearance, daily routines and rhythms, forms of address, and rights and privileges consistent with the person's chronological age and cultural environment. Indicators include, but are not limited to:
  - Typical schedules for work or school, mealtime, and leisure activities.
  - Freedom of choice and movement.
  - Typical dress, personal appearance, personal possessions, and social and sexual behavior.
- Services and settings should provide opportunities for interaction in groups that are typical for groups in the community in terms of size, composition, and nature. Indicators include, but are not limited to:
  - The number of people in a group.
  - The appropriate grouping of persons by age and areas of interest.
  - The likelihood of the group being viewed by the community as different or negative.

- Services and settings should ensure that the physical and social environment provide expectations, experiences, and challenges appropriate to the person's developmental level, chronological age, and language abilities and provide the opportunity for personal growth and development. Indicators include, but are not limited to:
  - Availability of learning opportunities that allow the person to face risks that are a typical part of normal growth and development.
  - Use of electrical appliances, cleaning supplies and cooking facilities.
  - Use of protective devices such as temperature controls on water, alarms, and security systems.
  - Use of public transportation.
  - Freedom to come and go without supervision.
  - Self-administration of medication.
- Services and settings should promote individualization and be provided in a way that respects and enhances the consumer's a sense of autonomy, privacy, dignity and self-esteem. Indicators include, but are not limited to:
  - Use of personal belongings.
  - Provisions for privacy.
  - Allowance for variance in routines and activities.
  - Opportunities for being related to as an individual as opposed to a member of a group.

These principles serve as a guide to the delivery of services, with consideration for the consumer's strengths, needs, and preferences. Consider the guidelines regarding age-appropriateness in relation to the service needs of the consumer.

The principle of normalization incorporates the principal of the least restrictive services and settings. Normalization is consistent with Iowa laws, because it encourages placement in the consumer's own community, if a suitable placement is currently available.

This principle does not prohibit the interdisciplinary team from recommending that the consumer be placed in an institutional setting. Normalization does not require placement at a new or higher level than that otherwise provided by law.

When services cannot be delivered according to these principles, document the reasons on the *Outcomes Achievement Plan.* This may include, but is not limited to, the lack of available financial resources.

Protection of Consumers' Rights

Legal reference: 441 IAC 24.2(5) and 24.2(10)

Persons with mental illness, mental retardation, and other developmental disabilities have the right to be treated in accordance with basic human, civil, and statutory rights. Inform consumers about how to express questions, concerns, complaints, or grievances regarding any aspect of their service. Consumers receiving targeted case management services have the right to enter into contractual agreements, as well as the right to:

- Privacy.
- Respectful treatment.
- Confidentiality.
- Due process.
- Acceptance or termination of services.

The following sections give more information on:

- Maintaining confidentiality.
- Obtaining consent for the release of information about the consumer.

Confidentiality

Legal reference: 441 IAC 24.2(5)

Disclose personally identifying information about the consumer's involvement in services, treatments, or evaluation in accordance with existing federal and state laws and regulations pertaining to confidentiality.

Obtain a signed release from the consumer before sharing any confidential information except when:

- Disclosure is permitted or required by law.
- There is a bona fide medical or psychological emergency.
- Disclosure is required for approval, certification, or licensure as a provider.

When releasing information without a signed consent, make a narrative entry that specifies what was released, to whom, and under what circumstances.

Use *Consent to Obtain or Release Information*, form 470-4729, to record the consumer's permission to share information. The form must:

- Be signed and dated by the consumer or legally authorized representative.
- Specify to whom the information can be released.
- Identify what is to be released and the reason for the release.
- Describe how the information is to be used.
- Specify the period of time the release is in effect.

Releases may be revoked at any time. Failure of a consumer or legally authorized representative to sign a release is not an automatic reason to deny services.

When securing the consumer's approval to request information from a third party, include a statement on the release of information that the information will also be accessible to:

- Board of supervisors, when the consumer's county subcontracts with the Department for targeted case management services.
- The managed care provider, when securing mental health services.

In a county that subcontracts with the Department for targeted case management services, you can provide information about a consumer to the county board of supervisors without a release.

For more information on specific limits on the acquisition and disclosure of mental health information, see I-C, **Mental Health Information**.

Informed Consent

Legal reference: 441 IAC 24.2(5)

Consent refers to time-limited, voluntary consent. Documentation that consent was secured is a protection necessary for both the targeted case manager as a practitioner and the state as an employer. The consumer's record must contain documentation of the following:

- That consent has or has not been secured.
- Who participated in the discussion.
- What information was discussed.
- How you determined that the consumer understood the impact of giving consent.

The consumer or legal guardian has the opportunity to ask and have questions satisfactorily answered. Information required to obtain informed consent includes a description of:

- The treatment and specific procedures to be followed.
- The intended outcome or anticipated benefits.
- The rationale for use, the risks of use and nonuse.
- The less restrictive alternatives considered.

Do not construe the provision of consent to mean that the consumer is waiving any legal rights. Such consent does not release the agency from negligence. The consumer or legal guardian may withdraw consent at any time without the risk of punitive action.

Use form MH-2201-0, *Consent to Release or Obtain Information*, when requesting the consumer or the consumer's legally authorized representative to release the OAP and other confidential information. This form meets the legal requirements for release of mental health information. (See I-C and I-C-Appendix for more information on these requirements and when information can be released without consumer's or legal representative's consent.)

When securing consent regarding the consumer's understanding of the Medically Needy spenddown payment process, your discussion must at a minimum address:

- That establishing full Medicaid eligibility through the Medically Needy program depends on encumbering a designated amount of money (spenddown) for medical services.
- That the consumer is informed about the amount of the Medically Needy spenddown.
- That the consumer acknowledges responsibility to pay any spenddown amount attributed to the DHS Targeted Case Management Unit and billed by the Unit to the consumer. (See 13-H-Appendix for billing procedures.)
- That DHS Targeted Case Management Unit will terminate services if the unit does not receive full payment of the amount due within 30 days of the second billing date.

- That the consumer understands that if targeted case management services are terminated for non-payment, full payment of the past-due amount must be made before re-approval for targeted case management services when eligibility is through the medically needy program with a spenddown.

Written informed consent from the consumer or legally authorized representative is required for participation in:

- Experimental treatment procedures.
- Procedures that carry an intrinsic risk, such as convulsive therapy, psychosurgery, or aversive conditioning.
- Targeted case management-sponsored research involving human subjects.
- Targeted case management-sponsored external training or demonstration projects involving the use of audiovisual equipment or two-way mirrors.

Intake and Evaluation

Legal reference: 441 IAC 24.2(1)

Initiate targeted case management services by completing the following activities in consultation with the consumer, the parents (if the consumer is a minor child), family members requested by the consumer, or the consumer's legal representative:

- Complete intake and assessment activities by using the *Assessment Worksheet*, form 470-3447, and *Assessment Summary*, form 470-3446 and *Social History*, form 470-3661. This is necessary to determine the consumer's need and desire for targeted case management services.
- Obtain and summarize information necessary to develop the *Outcomes Achievement Plan*.
- Complete the *Functional Assessment Tool* (FASST), form 470-3073, for consumers requesting participation in HCBS mental retardation waiver services.

Complete the *Annual Report* at the initial and any subsequent assessments. It includes the following information:

- Consumer's current functioning in the areas of safety, health, self-sufficiency and stability.
- Other factors affecting current functioning.

- Areas of strength and need identified in the *Assessment Worksheet*, form 470-3447. Include other needs, such as additional service needs, evaluations needed or recommendations for a guardian or conservator, if applicable.
- Desired results based on needs and strengths identified in assessment.
- Wants identified by the consumer.
- Other factors affecting the current situation
- Responses to past interventions.

The *Social History* contains current and historical information that is to be updated annually, describing in narrative style the following areas:

- Cultural History: Any relevant cultural factors, including ethnic, religious, environmental, and socioeconomic background.
- Familial History: Relationships and interactions the consumer has with family members, significant others, and support systems.
- Developmental History: Relevant childhood developmental stages.
- Psychosocial History: Relevant information about the onset or cause of the consumer's disability, substance abuse history, academic history, competitive employment, volunteer work, behavioral, social functioning, etc.
- Physical History: Any relevant physical or medical information, such as the history of illness and injuries, chronic medical problems, and special diets or therapies. This could also include medications that have been tried and not worked, to establish documentation of medication history.
- Legal History: All involvement with the legal system, including guardianship, conservatorship, payee, arrests, convictions, lawsuits, involuntary commitments, etc. Reference any court documents reviewed and specify the location of these documents. Summarize pertinent outcomes. If multiple actions have been taken, address these in chronological order of occurrence.
- Service History: Provide a brief summary of the service history in chronological order, including vocational, mental health, educational, and residential information. Briefly address if the service was successful and if not, why not.

This information serves as the basis for planning a program of services for the consumer. Use the results of past evaluations if they reflect the current status of the consumer.

Assist the consumer in obtaining any additional information or evaluations that may be necessary to meet these requirements. Schedule evaluations within 30 calendar days of acceptance for service. Evaluations must be completed by persons appropriately qualified in the area of functioning being evaluated.

Service Planning

Legal reference: 441 IAC 24.2(2), 24.2(3) 24.2(7), 24.3(1), and 25.20 (225C)

The *Outcomes Achievement Plan* (OAP), form 470-2560, documents the consumer's plan for services. Base the OAP on information identified in the *Assessment Summary,* form 470-3446, and *Social History*, form 470-3661. Develop and implement an OAP that:

- Addresses all relevant services, resources and natural supports provided.
- Is completed within 60 calendar days of acceptance for services.
- Is in a permanent, written form.
- Is dated and signed by each member of the interdisciplinary team.
- Is available to the consumer and all providers authorized by the consumer to receive a copy.

The *Outcomes Achievement Plan* identifies the service activities designed to enable a consumer to maintain or move toward independent functioning. It identifies a continuum of development and outlines progressive steps, anticipated outcomes of services, and promotes consumer choice, where appropriate.

Approval of this document by the consumer or the consumer's legally authorized representative and interdisciplinary team members authorizes plan implementation.

Follow the priorities specified in the county plan and the contract, except when receipt of targeted case management is a condition for approval or an eligibility requirement for another program, such as the HCBS waiver programs. A court order takes precedence over the priorities in the county plan and the contract

Information about service planning is organized into the following sections:

- Developing the OAP with an interdisciplinary team.
- OAP content.
- Distributing the OAP.
- Implementing the OAP.
- Revising the OAP.

Developing the OAP With the Interdisciplinary Team

Legal reference: 441 IAC 24.3(1)

Assist the consumer in identifying the members of an interdisciplinary team that includes other organizations and individuals of the consumer's choice to assist in developing the plan. Notify all team members of the purpose, time, and place of the team meeting.

If a team member will not be able to attend, make a reasonable effort before the meeting to review with that person the needs of the consumer and those services the team member can provide. A team member may participate by telephone if unable to attend in person.

The interdisciplinary team should begin by reviewing and clarifying the needs of the consumer, as indicated by the summary information provided. The team identifies the goals and objectives that will address the consumer's needs and the services, settings, and living arrangements that are needed.

Follow up with any team members that were not able to attend the meeting and were identified to provide services. Obtain their agreement to and signatures on the plan, or document their objections.

Ensure that:

- The OAP is free of professional jargon and is in language that is understandable and usable for the consumer and lay persons involved in its development and implementation.
- Representatives of primary funding sources have assured that funds are available for each of the services identified in the OAP before the OAP is approved.
- The service plan documents are prepared using forms 470-3446, *Assessment Summary,* and 470-2560, *Outcomes Achievement Plan,* and these forms are submitted for typing within 10 working days of the team meeting.
- Typed copies are mailed to team members within 15 working days of the team meeting.

For the initial request of consumers applying for HCBS MR or BI waiver services:

- Submit the applicable functional assessment tool and SS-1645, *Home- and Community-Based Service Report,* to the Iowa Foundation for Medical Care to secure a level of care determination.

  Note: For children applying for HCBS MR waiver, ensure that the social work case manager completes and submits the assessment tool and SS-1645 to IFMC. For consumers applying for HCBS BI waiver, the IM worker will send the assessment tool to the discharge planner at the facility where the applicant resides, and the SS-1645 directly to IFMC. Ensure that the discharge planner completes the assessment and submits it to IFMC.

- For consumers funded by a county of legal settlement, secure county approval by submitting copies of the *Medicaid Home and Community- Based Services Agreement,* form MA-2171.

- Secure final approval for HCBS waiver services by submitting copies of the following to the Division of Medical Services, Bureau of Health Care Purchasing and Quality Management:

  - RS-1238, *Eligibility for Medicaid Waiver*, prepared by the IM worker.
  - SS-1645, *Home and Community-Based Services Report.*
  - 470-3280, *Consumer Data Entry*.
  - MA-2171, *Medicaid Home and Community-Based Services Agreement.*

Outcome Achievement Plan Content

Legal reference: 441 IAC 24.2(2), 24.2(3), 24.2(4), 24.2(5) and 24.3(1)

The *Outcomes Achievement Plan* (OAP), form 470-2560 is organized into the following sections:

- Crisis intervention plan.
- Goals and objectives.
- Rights restrictions.
- Targeted case management discharge plan.
- Consumer rights.
- Consumer responsibilities.
- Team agreement and signatures.
- Right of appeal.

Secure signatures of those present for the OAP staffing (including the consumer and legally authorized representative) on the Team Agreement and Signature page.

Note any written objections to the contents of the plan in the remarks section of the OAP.

The appeals page provides the consumer and other team members with a detailed outline on how to file an appeal, time limits, continuation of services, granting a hearing and presenting the case. Any member of the team who is dissatisfied with the OAP may request a review through the Department's appeal process. See **Appeals** in this chapter for details.

Crisis Intervention Plan

Legal reference: 441 IAC 24.3(1)

The crisis intervention plan must include:

- An emergency contact person.
- A detailed list of the people the consumer or someone acting on the consumer's behalf should contact in the event of an emergency.
- A plan specific to the individual consumer's needs (for example a mental health plan, a medical emergency plan, or both) including natural supports that should be contacted before calling the emergency contact person.

In addition, include the following, if determined necessary and appropriate:

- Name, address, and telephone number of the consumer's physician and hospital of choice.
- Medical information, such as:
  - Drug and food allergies.
  - Current prescribed and non-prescribed medications being taken by the consumer.

Goals and Objectives

Legal reference: 441 IAC 24.3(1)

The written *Outcomes Achievement Plan* must contain the following information:

- Individualized goals, which are general statements of expected accomplishments to be achieved in meeting the needs identified in the *Assessment Summary*, form 470-3446. The goal should be consumer-driven and involve consumer collaboration as well as agreement. The goal should relate to specific outcomes that have been identified as desired results.
- Background (baseline) information that is a short summary of the consumer historical perspective related to the goal. This will help you determine the original starting point when reviewing progress.
- Objectives that are specific, measurable, and time-limited statements of outcomes or accomplishments necessary for progress toward each goal.
- Specific services or service activities to be provided to achieve the objectives, based on appropriateness, availability, and accessibility of the services and financial resources. Identify:
  - The task to be completed.
  - Specific persons or providers to complete the task.
  - Start date of the task.
  - Anticipated date of completion.
- Case manager responsibility regarding the service activity. Include time frames and tracking methods for monitoring progress on each service activity.
- Specific information related to the goal, objective, service activities, tasks or responsibilities in the comment section. For HCBS waiver consumers, include the following information in the comment section:
  - All services received at waiver enrollment.
  - Amounts of waiver services to be provided.
  - For supported community living:
    - Living environment at time of waiver enrollment.
    - Number of hours per day of on-site staff supervision.
    - Number of other consumers to live with waiver consumer.

Rights Restrictions

Legal reference: 441 IAC 24.2(5)

Consumer rights can be limited or restricted only with the consent of the consumer or the consumer's legally authorized representative, within these guidelines:

- Identify the right to be limited.
- Explain how the right is limited.
- Develop a service activity to address the restriction and explain how the consumer will work toward having the restriction removed.
- Conduct periodic evaluation of the limit to determine continued need.

If there are numerous restrictions identified, the team may prioritize the order in which the restrictions will be programmed. For restrictions identified for programming, develop a service activity and include the activity in the *Outcomes Achievement Plan.*

There may be restrictions in which there is no programming (for example, certain physician-ordered medical conditions, facility policies, court orders and guardian requests). List this information with each right restriction, if applicable.

Targeted Case Management Discharge Plan

Legal reference: 441 IAC 24.2(4)

The team shall discuss when discharge from targeted case management may be appropriate. Develop a plan for discharge and include the plan in the *Outcomes Achievement Plan.* Base the plan on the consumer's assessed needs, abilities, situation, and desires. The discharge plan shall include the following:

- Time frames for discharge.
- Need for targeted case management as it corresponds with the goals and objectives.
- What needs to happen for the consumer to be discharged.

Consumer Rights and Responsibilities

Legal reference: 441 IAC 24.2(3), 24.2(5)

The consumer rights page of the *Outcomes Achievement Plan*, lists the rights and responsibilities of each DHS targeted case management consumer. Discuss the contents of the Consumer Rights section with the consumer or the consumer's representative.

Review the rights and responsibilities annually. Secure the consumer's or guardian's signature on the *Outcomes Achievement Plan* signature page following the discussion to verify that the rights were reviewed.

The signature documents that the rights have been reviewed and that it is understood targeted case management is a voluntary service and can be terminated at any time by notifying the targeted case manager. The signature also acknowledges that if the consumer receives HCBS services, targeted case management services are required.

Distributing the Outcomes Achievement Plan

Legal reference: 441 IAC 24.2

In accordance with statutes and regulations on confidentiality, the *Outcomes Achievement Plan* is available to:

- The consumer.
- The consumer's legally authorized representative.
- The service providers.

The consumer's agreement to implement the *Outcomes Achievement Plan* constitutes authorization to provide copies of the OAP to those providing the services described in the OAP.

Before distributing an *Outcomes Achievement Plan* including HCBS waiver services, secure final approval from the Division of Medical Services, Bureau of Health Care Purchasing and Quality Management, as required by 16-K(4) or 16-K(5), **ELIGIBILITY CRITERIA**.

Document in the narrative refusals to release copies of the plan, the reasons for the refusal and the potential impacts on implementation of the plan.

A representative of the payer, other than an elected official, shall have access to the *Outcomes Achievement Plan* in accordance with laws and regulations on confidentiality, for purposes of:

- Monitoring and evaluating the delivery of service in accordance with the terms of any contract between the payer and the provider.
- Ensuring compliance with service standards.
- Planning for services.

Boards of supervisors in counties subcontracting with the Department may request and receive copies of the *Outcomes Achievement Plan.*

Implementing the Outcomes Achievement Plan

Legal reference: 441 IAC 24.2(2)(225C)

To implement the *Outcomes Achievement Plan*:

- Encourage consumer choice and assist the consumer to obtain the services and supports identified in the OAP.
- Coordinate and facilitate decision-making, as well as services, among providers to ensure consistency in the implementation of the OAP.
- Monitor the services and supports identified in the OAP to ensure these continue to be necessary and appropriate.
- Contact the consumer and providers as specified in the OAP. Have face-to-face contact with the consumer quarterly.

Consumers may avail themselves of services which may be paid for through a variety of funding sources. For adult consumers, coordinate all services to the consumer. For children, coordinate waiver services and services specific to the child's disability, such as educational services or services from a health care practitioner.

Note: Do not implement the OAP for a consumer applying for HCBS waiver services until the Bureau of Health Care Purchasing and Quality Management has given final approval for HCBS waiver services as specified in 16-K(4) or 16-K(5), **ELIGIBILITY CRITERIA**. Any OAP implemented before that approval must have services funded by other sources and must not include any HCBS waiver services.

When rehabilitative treatment and supportive services (family-centered services and foster care services) or court-ordered services are provided to the child or the child's family, communicate with the social work case manager to identify which Department worker has primary responsibility for:

- Monitoring each service provided.
- Coordinating authorization of rehabilitative services.
- Arranging staffings
- Sending notifications.
- Providing collaboration and coordination of services.
- Completing required reports and plans.

Document monitoring and contact with the consumer and providers in the consumer's record within in seven days.

If the team identifies service needs that cannot be met by the providers represented on the team, contact or assist in contacting providers to obtain the needed service in accordance with the OAP. If a provider is located, obtain agreement to the OAP. If a provider cannot be located, document this on the OAP. Notify the team members and modify the OAP.

Ensure that service activities identified in the OAP are provided by persons or agencies who are appropriately qualified for the provision of those activities and that these persons or agencies are licensed or certified, when applicable.

Obtain copies of any provider plans for implementing services identified in the OAP.

Reviewing the Outcomes Achievement Plan

The following sections describe requirements for:

- Review of the consumer's progress.
- Annual review of the *Outcomes Achievement Plan.*

Review of Consumer Progress

Legal reference: 441 IAC 24.2(1)

At least quarterly, determine and document the consumer's progress on service activities identified in the *Outcomes Achievement Plan* on form 470-2561, *Targeted Case Management Service Activities Benchmark.*

Complete the initial benchmark three months after the OAP meeting was held. Base the determination on your documentation in the narrative and reports submitted by the consumer, the guardian, or providers identified in the *Outcomes Achievement Plan.*

When choosing a rating for the quarterly benchmark review, compare the progress for the consumer from the background (OAP or baseline) data. Review progress in relation to the goal and objective, not in relation to previous benchmark progress.

For those counties requesting quarterly reports, take information from the *Service Activities Benchmark* and combine it with other necessary information to prepare a brief report summary.

Annual Review

Legal reference: 441 IAC 24.2(1)

At least annually, complete the *Assessment Worksheet,* form 470-3447, in coordination with the interdisciplinary team. This is done to document the consumer's level of functioning and need for services in the following areas:

- Safety
- Health
- Self-sufficiency
- Stability

Complete the *Assessment Summary,* form 470-3446, whenever an *Assessment Worksheet,* form 470-3447 is completed. See **Intake and Evaluation** in this chapter for details on these forms. Review the *Social History,* form 470-3661, at least annually.

Review the findings of the *Service Activities Benchmarks,* form 470-2561, on consumer progress with each service activity; provider reports; and information from the consumer and the consumer's significant others.

Request additional evaluations as needed. This information shall direct and support goals for the next years *Outcomes Achievement Plan,* which is based on the consumer's identified strengths, needs and abilities.

For recertification requests for HCBS MR or BI waiver services:

- Ensure that the Iowa Foundation for Medical Care certifies at least annually level of care by submitting the applicable functional assessment tool.
- Secure county approval at least annually by submitting copies of the *Medicaid Home and Community- Based Services Agreement,* form MA-2171, for consumers funded by a county of legal settlement
- Secure final recertification approval by submitting copies of the following to the Division of Medical Services, Bureau of Health Care Purchasing and Quality Management:
  - 470-3280, *Consumer Data Entry* (if there are any changes since the last form was completed).
  - MA-2171, *Medicaid Home and Community-Based Services Agreement.*

Do not implement the new OAP until the Bureau of Health Care Purchasing and Quality Management has given final approval for HCBS waiver services as specified in 16-K(4) or 16-K(5), **REDETERMINATION**. Any OAP implemented before that approval must have services funded by other sources and must not include any HCBS waiver services.

Revising the Outcomes Achievement Plan

Legal reference: 441 IAC 24.2(2)

Revise the *Outcomes Achievement Plan* whenever the plan for the consumer is modified, changed or reviewed (no less than annually). Use the findings of the *Assessment Summary,* form 470-3446 to revise the OAP.

Complete a new *Assessment Worksheet,* form 470-3447, and *Assessment Summary,* form 470-3446, at your discretion, based on the degree of change, situation, etc. (but no less than annually.) Follow the procedures under **Developing the OAP With the Interdisciplinary Team** and **Distributing the Outcomes Achievement Plan**.

For consumers receiving HCBS waiver services, also complete the documents required by any changes in services (provider, hours, rates, etc.):

- For consumers funded by a county of legal settlement, secure county approval for the change by submitting copies of the *Medicaid Home and Community- Based Services Agreement,* form MA-2171.
- Secure final approval of the change by submitting copies of the following to the Division of Medical Services, Bureau of Health Care Purchasing and Quality Management:
  - 470-3280, *Consumer Data Entry* (if there are any changes since the last form was completed).
  - MA-2171, *Medicaid Home and Community-Based Services Agreement.*
- Ensure that level of care approval is secured from the Iowa Foundation for Medical Care at least every 12 months as required by 16-K(4) or 16-K(5), **REDETERMINATION**.

Do not implement changes in the *Outcomes Achievement Plan* until the Bureau of Health Care Purchasing and Quality Management has given final approval for HCBS waiver services as specified in 16-K(4) or 16-K(5), **ELIGIBILITY CRITERIA**. Any OAP implemented before that approval must have services funded by other sources and must not include any HCBS waiver services.

Termination of Services

Legal reference: 441 IAC 78.33(249A), 24.2(4) and 130.5(2)"j"

Terminate targeted case management services in the following situations:

- The consumer is receiving targeted case management services from another source.
- The contract with the consumer's county of legal settlement is terminated for a non-Medicaid-eligible consumer.
- The Medicaid-eligible consumer has legal settlement in a county whose contract designating the DHS Targeted Case Management Unit as the provider of services has terminated, and the county is not willing to approve continued DHS-provided targeted case management services.
- The consumer has achieved all goals and objectives of the service.
- The consumer has no current targeted case management needs identified by the interdisciplinary team during a review.
- The consumer no longer meets the definition for the target populations.
- A Medicaid-funded consumer is no longer Medicaid-eligible.
- A non-Medicaid-funded consumer no longer meets the eligibility criteria delineated by the county of legal settlement.
- The consumer receiving targeted case management services based on eligibility under an HCBS waiver is no longer eligible based on the termination criteria listed on 16-K(4) or 16-K(5), **Termination**.
- The consumer or the consumer's legally authorized representative requests termination.
- The consumer is unwilling or unable to accept further services.
- The consumer or the consumer's legally authorized representative fails to provide access to information necessary for the development of the OAP or implementation of targeted case management responsibilities.
- A consumer receiving targeted case management services while conditionally eligible through the Medically Needy program has not paid the fee for case management services within 30 days of the date on the second invoice sent to the consumer by the Department Targeted Case Management Unit.

Notify the consumer or the consumer's legally authorized representative of termination of targeted case management service using *Notice of Decision: Services,* form SS-1104-0. (See 13-H-Appendix.) **Exception:** Use a letter instead of form SS-1104-0 when the termination is based on termination of a county contract. At a minimum, the letter must include the following:

This is to notify you that the targeted case management unit located in <*name*> county will not be serving you after June 30, <*year*>.. We cannot continue to provide case management services to you, as our agreement with <*name*> county expires June 30, <*year*>..

<*name*> county has named <*provider name*> to provide targeted case management services in your county beginning July 1, <*year*>.. You may contact <*name, address, and phone number*> if you wish to apply for targeted case management services to continue after July 1.

Copies of this letter are being sent to the members of your interdisciplinary team to let them know of this change. The OAP that we developed with your team will not be valid after June 30, <*year*>. Also, the Releases of Information that you signed to permit us to share information with other members of the team will not be valid after June 30, <*year*>.

If you have any questions about this, please contact <*name, title, address, and phone number*>.

Appeals

Legal reference: 441 IAC Chapter 7 and 441 IAC 24.2(5)

Any person who is dissatisfied with any decision of the targeted case manager may request a review of the targeted case manager's decision through the Department's appeal process. The Department appeals process includes:

- A written request by the aggrieved party.
- A pre-hearing conference with a representative of the Targeted Case Management Unit.
- A hearing before an administrative law judge employed by the Department of Inspections and Appeals.
- A proposed decision issued by the administrative law judge.
- The opportunity for either side to request a review of the proposed decision.
- A final decision issued by the director of the Department of Human Services.

If the dispute is not resolved through the appeal process, the dissatisfied person may seek judicial review of the targeted case manager's plan or other appropriate process if applicable. See 1-E, **RIGHTS OF APPELLANTS AFTER THE FINAL DECISION**, and 1-E-Appendix for details.

Termination based on county contract expiration is not appealable, as services to the consumer are not being terminated. The provider of services is changing due to the expiration of the contract with one provider and the initiation of a contract with another provider. Other services provided are not being terminated, as a social work targeted case manager will assume those responsibilities through a case transfer.

RECORDS

Legal reference: 441 IAC 79.3(249A) and 24.2(8)

The case record is established to provide the record for an individual consumer. The fiscal records must support each item of service for which a charge is made to the program. The case records must specify:

- The procedures performed.
- The dates of service, or other supplies or services prescribed or provided to the consumer.
- Information concerning progress of treatment.

The case record is the responsibility of the targeted case manager. Targeted case management supervisors are responsible for reviewing case records and ensuring that standards are met.

The following sections give more detail on:

- Required content for case records.
- Requirements for case narrative.
- Procedures for transfer of records.
- Procedures for sharing information with other Targeted case management providers.
- Requirements for record retention and destruction.

Content

Legal reference: 441 IAC 24.2(8)

The consumer's case record shall contain at a minimum:

- Consumer identifying information, including the consumer's:
  - Name.
  - Current address.
  - Telephone number.
  - Date of birth.
  - Gender.
  - Ethnic origin.
- The name, address and telephone number of the consumer's guardian, approved contact person, or other legally designated person.
- The name, address and telephone number of the person to be notified in case of emergency.
- The consumer's sources of income.
- The legal status of the consumer, as well as the consumer's legal settlement.
- Results of the initial assessment, diagnoses and evaluations, and the annual assessment summary.
- *Outcomes Achievement Plan* (OAP), progress reports, and related entries.
- Copies of authorizations to release or obtain information.
- Correspondence to, from, or regarding the consumer.
- Documentation of the targeted case manager's:
  - Activities.
  - Contacts with the consumer, other service providers, and the consumer's family.
- Documents required to verify eligibility for and support participation in HCBS waiver services. Specific requirements for HCBS MR are found in 16-K(4), **Individual Comprehensive Plan**, **Choice of Program**, **Home and Vehicle Modifications**, and **County Reimbursement**. Specific requirements for HCBS BI are found in the comparable sections of 16-K(5).

Design

Legal reference: 441 IAC 24.2(8)

Develop a separate case record for each targeted case management consumer. At a minimum, the case record must contain the following:

- *Assessment Summary*, form 470-3446.
- *Service Reporting System,* form RS-1120, with the most current on top.
- *Consent to Release or Obtain Information* (form 470-0429).
- Eligibility information (documentation of age, resources, etc.), most current on top, including:
  - Applications (form SS-1120-0).
  - Notices of decision (form SS-1104-0).
- Other pertinent forms, with the most current on top.
- HCBS waiver forms (470-3280, MA-2171, SS-1645, RS-1238, 470-3229, 470-3073).
- Service planning documents, with the most current on top (*Outcomes Achievement Plan*, form 470-2560 (on top), *Assessment Worksheet,* form 470-3447).
- Benchmark Review forms (*Service Activities Benchmark,* form 470-2561).
- Case narrative.
- Diagnostic and evaluation reports (all components, to include any social histories obtained from providers or evaluators) with the most current on top.
- Other reports, with the most current on top.
- Correspondence, with the most current on top.
- Legal documents, with the most current on top.

The targeted case management unit has the following options:

- Determining the size of folders used.
- Using a central or a caseload filing system, as long as the office has all records readily available upon demand.

Narrative

Legal reference: 441 IAC 24.2(3)

The purposes of case narratives are to:

- Ensure that follow-up on identified problems has occurred.
- Document significant monthly contacts.
- Substantiate that the contacts made warrant billing.
- Document ongoing compliance with standards regarding targeted case management services.
- Document consumer's progress toward *Outcomes Achievement Plan* goals.
- Provide chronological reporting of case activity, including:
  - Why the consumer entered services.
  - What needs to be done.
  - Eligibility (if not documented elsewhere).
  - How things will be done.
  - Actions taken by the team and targeted case manager.
- Provide information for program evaluation.
- Ensure continuity of care, which includes providing for coverage of consumer's needs in the event of a change in targeted case managers.

In addition to the materials identified in **Contents**, document in the case narrative:

- How you have adhered to or diverged from the principles outlined under **Service Delivery Principles**.
- How your actions foster consumer involvement in the OAP process.
- How your face-to-face and other consumer-related contacts relate to the consumer's goals and objectives.
- The consumer's reactions to your interventions.
- What level of decision making is exercised by the consumer.
- What you are doing or have done to increase the consumer's decision-making skills.

Minimum Narrative Format Requirements

Narrative entries can be summarized for multiple contacts. You may choose to summarize for several days, or make individual daily entries. The summary can include, at a maximum, one week (seven calendar days) of contact.

Each record must have a minimum of one signed entry per month. Each narrative entry shall include the following:

- Date of case activity (time optional).
- Headings for type of case activity:
  - Face-to-face consumer contact.
  - Phone call with consumer.
  - Collateral contact.
  - Combined face-to-face and collateral contact.
  - Case note (optional).
  - Legal settlement (optional, when no other written verification is available). Describe the determination of the consumer's county of legal settlement or the consumer's approval for the State Payment Program for services to adults and where the verification is filed.
  - Consent (optional, available per worker discretion). Can be used to document that options are discussed with a consumer making a decision. State who was involved in the discussion and provide a summary of the discussion and outcomes.
  - Medicaid eligibility (optional, when no other written documentation is available). Describe how Medicaid eligibility was determined.
- Duration of contact. (Include in heading.)
- Location of contact or who contact was with.
- Date narrative was written or dictated (if dictated).
- Date narrative was typed.
- Typed initials of person making the entry (if done by someone other than the case manager whose name appears at the bottom of the page).

- Typed initials of person typing the entry (if typed by someone other than the case manager whose name appears at the bottom of the page).
- Signed initials of the person responsible for making entry at the bottom of each printed page of narrative. If someone other than the primary case manager makes an entry, include a full name signature.
- Dates and to whom materials were sent (when there is no cover letter), including
  - *Outcomes Achievement Plans.*
  - Notification of staffings.
  - Referrals for service.
  - Any other documents or correspondence issued to or on behalf of the consumer.

  When support staff mail out documents, responsibility for making the record entry can be delegated to the support staff. A copy of a cover memo that accompanied the material sent can serve as documentation when filed in the record.

  You may note all incoming and outgoing correspondence in the narrative as deemed appropriate.
- Notation of the basis for serving a consumer under an exception, such as a consumer whose legal settlement or diagnostic category would not regularly fall within the responsibility of the office providing services.

Record Transfer

When an active Department targeted case management recipient moves to a different location within the state and the lead supervisors have agreed to transfer case responsibility, immediately transfer the case record to the new location by first class mail, hand delivery, or courier service.

Do not transfer case records of closed or deceased targeted case management recipients, except when specifically requested by another DHS targeted case management unit. An office may choose to prepare or retain a skeleton case file on transferred records. However, always keep sufficient information (or a description of the location of the material) to support delivery of services for which payment has been received.

Transfer of Closed Cases to Social Work Case Management

Legal reference: 441 IAC 79.3(249A)

When transferring a case to social work case management, after closure or termination of DHS targeted case management services, keep sufficient information to support delivery of services for which payment has been received.

Retain in the closed targeted case management record the originals of the materials required to support the provision of targeted case management services in compliance with all standards and requirements. Include copies of these materials in the record transferred to social work case management. Copies of other material included in the record transferred to social work case management may be kept in the closed targeted case management record.

Keep the originals of the documents generated during the provision of targeted case management services in the closed targeted case management file. Include copies in the file transferred to social work case management. These original documents minimally include:

- Service plan documents (ICPs and OAPs).
- Quarterly progress reports.
- Narrative entries.
- Notices of decision.
- Releases of information.
- Enhanced service reports.
- Evaluations, psychological and psychiatric reports provided to targeted case management by medical practitioners, psychologists, or others.

Send a memo for each record transferred to social work case management identifying:

- The record being sent.
- Where the closed targeted case management records will be housed.
- The date the next SRS review is due.

Sharing Information With Other Targeted Case Management Providers

Legal reference: 441 IAC 9.3(6) and 9.3(7)

When a different provider is to begin serving a consumer for whom the Department has been providing targeted case management services, notify the consumer or the consumer's legally authorized representative that another provider has been designated to provide targeted case management.

Upon receipt of a release of information, send the following information to the new provider to facilitate continuation of services to the consumer:

- A copy of the most recent *Outcomes Achievement Plan.*
- Copies of the quarterly progress reports completed since the OAP was completed.

Note: If the most recent service plan completed was the OAP, then there will not be any quarterly progress reports to send to the new provider. Do not send the *Service Activities Benchmark*.

When additional information from the consumer's record is requested and that information is not protected by state and federal rules on confidentiality:

- Send the packet of information specified in policy, with a cover memo that indicates that additional information requested will be provided at a cost of $0.10 per page, $9 per hour of staff time or fraction thereof, and actual mailing costs.
- Request written authorization from the requesting agency and provide an estimate of the cost.
- Upon the receipt of written authorization, copy the requested information and send it to the requesting agency with an invoice for the cost of the copies and time.
- Write the invoice on DHS letterhead. Direct payment of the amount due to DHS Targeted Case Management Unit, Hoover Building, Des Moines, Iowa 50319-0114.
- Send a copy of the invoice to the DHS Targeted Case Management Unit accountant in the Hoover Building. Upon receipt of payment, the accountant will notify the targeted case management unit that sent the invoice. Payments shall be shown as an expense recovery for the unit that sent the invoice.

Post a copy of the policy regarding costs of providing information from records in each office of the DHS Targeted Case Management Unit that has support staff.

Record Retention and Destruction

Legal reference: 441 IAC 79.3(249A)

Maintain records in support of services for which a charge is made either to the Medicaid program or to a county. Make these records available to duly authorized representatives of the Department on request.

Keep the case and fiscal records for five years after the case is closed. Retain records to provide:

- Documentation of adherence to fiscal policies.
- Justify services delivered under either Medicaid enhanced services funding or 100% county funding.

Records may be destroyed after five years of inactivity. Destroy service case records according to policies and procedures established by the State Records Commission and found in the state Records Management Manual.

BILLING

The claim unit for targeted case management services is a calendar month. Service provided during any portion of a calendar month is considered a full unit of service for claim purposes.

Submit a claim only when you have completed the minimum level of case management service activity per consumer per month. The minimum billable activity is one or more contacts with or on behalf of a consumer documented in the consumer's file, with face-to-face contact at least quarterly.

The accounting technician enters the information into the accounts receivable system.

The following sections describe procedures for:

- Billing Medicaid through the fiscal agent.
- Billing Medicaid through the managed care contractor.
- Billing counties of legal settlement for cases that are not eligible for Medicaid.
- Billing for private-pay consumers.

Billing Medicaid Through the Medicaid Fiscal Agent

Legal reference: 441 IAC 78.33(249A)

Submit form 470-2464, *Report for Enhanced Services*, before submitting a claim for services rendered to a Medicaid-eligible consumer.

The accounting technician provides a list of the targeted case manager's assigned case load for the month of service being billed. The case manager reviews the list and indicates whether or not the consumer was served for that month. This confirmation of service is returned to the accounting technician as a source document for billing purposes.

Do not submit claims for consumers conditionally eligible through the Medically Needy program until the medically needy spenddown amount has been assigned.

The Medicaid fiscal agent sends a monthly *Remittance Statement*. The *Remittance Statement* contains three sections:

- PAID CLAIMS contains all processed claims, credits, and adjustments for which full or partial reimbursement is being made in this payment.
- CLAIMS DENIED contains all processed claims that have been denied (no reimbursement made), stating the denial reason in each case.
- CLAIMS IN PROCESS contains all claims that are suspended or currently in process pending resolution of one or more issues (consumer eligibility determination, reduction of charges, third party benefit determinations, etc.).

See 8-Appendix, ***Case Management Provider Manual***, Chapter F, for samples of each section of the *Remittance Statement*, including detailed field-by-field descriptions of each line.

Reconcile each remittance statement to ensure that all claims have been paid appropriately. Note remittances in the check log and cash receipts' journal and deposit them in the specified revenue line. Correct denied claims and resubmit them to the fiscal agent within five working days of receipt of the *Remittance Statement.*

Billing Medicaid Through the Managed Care Contractor

See the ***Medicaid Provider Manual*** in 8-Appendix for instructions on how a consumer is enrolled in the Iowa Plan**.**

The accounting technician provides a list of the targeted case manager's assigned caseload for the month of services being billed. The case manager reviews the list and indicates whether or not the consumer was served for that month. This confirmation of service is returned to the accounting technician as a source document for billing purposes.

Reconcile each remittance statement to ensure that all claims have been paid appropriately. Note remittances in the check log and cash receipts' journal and deposit them in the specified revenue line. Correct denied claims and resubmit them within five working days of receipt of the Remittance Statement.

Billing Counties of Legal Settlement (Non-Medicaid)

When the county of legal settlement contracts service for a non-Medicaid eligible consumer, the county shall specify billing protocols. When billing for service funded by the county:

- The targeted case manager must notify the accounting technician that case management services were provided.
- The accounting technician prepares and sends a statement to the county of legal settlement and a copy to the accountant in the Hoover Building. The accounting technician enters the information into the accounts receivable system.
- Central Office notes remittances from the county in the check log and cash receipts' journal and deposits them in the specified revenue line.
- Central Office notifies the accounting technician of the remittance from the county of legal settlement.
- The accounting technician enters the information into the accounts receivable system.

Billing for Private-Pay Consumers

A consumer using personal funds for the full cost of targeted case management must complete a private pay agreement before service is initiated.

When billing for a private-pay consumer:

- By the 15th of the month preceding each month services are to be provided, the case manager sends a memo to the accounting technician verifying that services are to be provided.
- By the 25th of the month preceding each month services are to be provided, the accounting technician sends a bill to the consumer for the full cost of case management services.
- The consumer must remit the full cost of case management by the first of each month in which targeted case management is to be provided.
- Central Office enters the remittance from the consumer in the check log and cash receipts' journal and deposits it in the specified revenue line.
- Central Office notifies the accounting technician of the remittance from the consumer.
- The accounting technician enters the information into the accounts receivable system.

ADMINISTRATION

The following sections explain:

- The DHS Targeted Case Management Advisory Board.
- Personnel administration.
- Procedures for county designation of DHS as the targeted case management agent.
- Procedures for communication with counties.
- Fiscal administration.
- The organizational plan of the DHS Targeted Case Management Unit.

Advisory Board

Legal reference: 441 IAC 24.2(7)

Mission statements of both the DHS Targeted Case Management Unit and the advisory board of DHS Targeted Case Management Unit are published in the annual report.

The advisory board consists of representatives from county boards of supervisors and providers serviced by DHS targeted case management. The Board meets at least quarterly. Members are expected to attend meetings as scheduled. Any board member or alternate missing three consecutive meetings, without just cause is considered to have withdrawn and a replacement will be sought.

Suggested terms for board members are two years. There is no limit on the number of terms a board member may serve. Replacement of board members is through appointment by the administrator of the DHS Targeted Case Management Unit from a list of nominees furnished by boards of supervisors served by DHS targeted case management.

Personnel Administration

Legal reference: 441 IAC 24.2(9)

As a state agency, the Department's policies and procedures for personnel administration are set by the Iowa Department of Personnel. See Department of Personnel manual, ***Personnel Management for Managers and Supervisors***, for specific policies regarding:

- Job descriptions (Chapter 3).
- Performance evaluation (Chapter 8).
- Personnel records (Chapter 14).
- General policies on staff orientation and training (Chapter 7).
- Equal opportunity and affirmative action policies (Chapter 2).
- Discipline and grievance procedures (Chapter 11).

Staff Qualifications and Duties

Legal reference: 441 IAC 24.1(225C), 24.3(1) and 24.2(7)

To provide targeted case management services, a person must meet the following minimum requirements:

- Have a bachelor's degree from an accredited college or university with a major or at least 30 semester hours in the behavior sciences, education, health care, human service administration, or the social sciences, and one year of experience in the delivery of human services with the education and experience being specific to the needs and abilities of each of the populations being served by the targeted case manager.
- Have an Iowa license to practice as a registered nurse with three years of experience in the delivery of nursing or human services to each of the population groups to be served by the targeted case manager.

The targeted case manager's immediate supervisor shall ensure that the following functions of supervision of targeted case management staff are carried out:

- Hiring.
- Assigning and monitoring of workload, including ensuring compliance with applicable standards.
- Directing and guiding persons assigned as case managers.
- Evaluating the performance of case managers
- Disciplining and discharging.
- Ensuring that training needs are identified and providing opportunities to meet those needs.
- Ensuring that environmental safety meets all federal, state and local regulations.
- Ensuring that there is a policy in place for the protection of consumers and staff.

Workload Ratios

Legal reference: 441 IAC 24.3(1)

Within a county or cluster of counties, the Department shall maintain an average staff-to-consumer ratio appropriate to the consumer's needs. The average caseload shall be no more than 45 consumers per targeted case manager. The ratio is based on current filled positions.

A full-time equivalent staff person means a filled targeted case manager position or a position vacant less than 45 days. "Filled" positions are those positions which are currently filled or are not vacant for more than 45 working days.

The Department determines the number of consumers per full-time equivalent case manager based on individual consumer needs. This staff-to-consumer represents the number of persons who can be effectively served.

The supervisor of each targeted case management unit is responsible for assigning cases to appropriate staff to keep the average staff-to-consumer ratio no more than one case manager to 45 consumers.

Orientation and Training

The Targeted Case Management Unit provides orientation and ongoing continuing education or in-service training all employees. This includes:

- An orientation program for all newly hired staff giving an introduction to Department organizational philosophies, structure, personnel procedures, safety procedures, risk management, confidentiality requirements, code of ethics, programs, and services and persons served.
- An orientation program for all new volunteers and student interns that addresses confidentiality requirements, safety procedures, roles, responsibilities, limitations, and procedures applicable to their responsibilities.
- Ongoing in-service training for all staff based on identified service needs and individual education needs.
- Mandatory reporter training for child and dependent adult abuse for all case managers and supervisors.

Core courses are available to staff of the Targeted Case Management Unit. Descriptions of the core courses are found in the Core Course Catalog. Non-core course training opportunities may also be available, depending upon funding.

Supervisors are responsible for:

- Ensuring that staff receive appropriate training.
- Assisting the staff in selecting relevant core course training.

Central office, regional office, and county office personnel are available to assist in this process.

Mandatory Reporting of Child and Dependent Adult Abuse

Legal reference: Iowa Code 232.69, 232.70, 235B.3; 441 IAC 24.2(9)

Department staff providing targeted case management services are mandatory reporters of child abuse and dependent adult abuse if they become aware of the suspected abuse in the course of their employment.

Case managers having knowledge of or reason to suspect child or dependent adult abuse are required to report the suspected abuse to the local protective unit within 24 hours.

Verbal reports must be followed by submission of a written report within 48 hours. Make the report on form 470-0665, *Report of Suspected Child Abuse,* or on form 470-2441, *Suspected Dependent Adult Abuse Report.*

For further information on child abuse reporting, refer to 16-E(2) and 16-E-Appendix. Dependent adult abuse information can be found in 16-G and 16-G-Appendix.

Conflict of Interest

Legal reference: 441 IAC 24.2(9)

In the provision of targeted case management, avoid situations where conflict of interest exists.

Because the Department is involved in the areas of planning, administration, funding, and delivery of targeted case management, it is possible that the interaction among these functions may be construed as conflict of interest. Employees at all levels should be cognizant of the possibility of situations involving potential conflict of interest.

Unless specifically stated to the contrary, no approved exclusion is considered to have application to any employee of the Department other than to the employee making the request for the exclusion. Any exclusions that are approved for broad application will be incorporated into XXI-M, **Conflict of Interest**.

If you are involved in or considering involvement in a situation that may be or appear to be a conflict of interest, or if you observe a situation involving another employee that may constitute a conflict of interest for that employee, report the matter to your supervisor.

The supervisor shall determine the propriety of the potential or existing situation. The determination must contain the following elements:

- Identification where conflicts do or could exist.
- Description of steps to eliminate or minimize those conflicts.
- Documentation of what the conflict is and how it was addressed in accordance with the best interest of the consumer, when conflicts arise.

If the supervisor determines the situation to be a conflict of interest, the affected employee may pursue an exclusion to the "conflict of interest prohibited activity" policy if the exclusion does not violate Iowa Code Chapter 68B or Chapter 18 of the Merit Rules.

To challenge a determination of conflict of interest, submit a written report through your immediate supervisor to the Targeted Case Management Unit administrator. Include information that explains the situation and attach any materials pertinent to the situation.

The exclusion request must specify:

- The reporting employee is the one involved in the possible conflict of interest situation.
- The employee plans to pursue an exclusion.
- Whether the situation is determined to be a conflict of interest.

The Unit administrator will review the matter, obtain any additional information needed and forward all materials along with a written recommendation to the chief of Office of Employee Services. The chief of the Office of Employee Services shall issue a final written decision.

Any employee who receives an approved exclusion shall report any changes in the approved activity that might affect the exclusion decision.

Designation by Counties

Legal reference: Iowa Code Section 225C.20

Medicaid-funded individual targeted case management services may be provided by the Department, a county or consortium of counties, or an agency under subcontract to a county or consortium of counties. All providers of targeted case management services are required to comply with the standards for targeted case management.

Counties may change the provider of targeted case management at any time. If the current or proposed contract is with the Department, the county board of supervisors must provide written notification of a proposed change to the Division of Mental Health and Developmental Disabilities by August 15 and written notification of an approved change by November 15 for the subsequent fiscal year.

Contracts With Counties

Legal reference: 441 IAC 25.6(225C)

The county or cluster of counties must enter into a contract with providers to be funded using county dollars for the provision of individual targeted case management services. (This requirement does not apply when the county has chosen not to designate a provider of targeted case management services.)

The county must provide the Division of MH/DD with a statement that identifies each provider that has entered into a contract with the county and the beginning and ending dates of the contract, and provide assurance that each contract meets the requirements.

A county or cluster of counties may choose to use a 28E agreement or other agreement to contract for Medicaid targeted case management services. Guidelines for the development of a 28E agreement can be found in Iowa Code Chapter 28E.

All contracts for the current fiscal year must be effective and assurances submitted to the Division by the start of the fiscal year on July 1. "Submitted" means postmarked or hand-delivered to the Division by the specified date. The contract is not effective until there is assurance of the availability of and access to funding. Provisions must include, but need not be limited to, the following:

- The length of time (beginning and ending dates) the contract is in effect.
- The estimated number of units of individual targeted case management services to be provided. This estimate must include:
  - An estimate of the number of persons with mental retardation or other developmental disability to be served through a combination of county, state and Medicaid funds.
  - An estimate of the number of persons with chronic mental illness to be served through the Iowa Plan.
- What constitutes a unit of service.
- A statement about the cost of the service, the projected amount to be paid by the county, the arrangements for payment and the time schedule for payment.
- Assurance of the provider's compliance with the Commission's standards for individual targeted case management services.
- Provisions for amending the contract only upon agreement of both parties or upon a change of availability of funds.
- Provisions for terminating the contract only upon failure to comply with the terms of the contract or upon the change in the availability of funds.

When the county designates the Department as the service provider, the county subcontracts with the Department using form 470-2584. These contracts are negotiated according to procedures in XXIII-F, ***Contracts***.

Department Responsibility When County Defaults

Legal reference: 441 IAC 25.5(4)

When the county has defaulted the decision to provide targeted case management services, the Department shall provide, within funds available, individual targeted case management services to persons in that county with mental retardation, developmental disabilities, or chronic mental illness who are eligible for Medicaid.

The Department will develop a plan that will address how the Department intends to provide Medicaid-funded targeted case management services in the county. The plan must include, but need not be limited to, the following information:

- The target population to be served, including age and disability groups.
- Projected number of persons to be served.
- Priorities for the order in which the people will be served.
- Assurances that the Department is in compliance with the standards established for staff qualifications for targeted case management providers.
- Identification of the source and amount of funds to be used for the service.

The county is considered to have defaulted the decision to provide targeted case management when:

- The county notifies the Division of Mental Health and Developmental Disabilities that it will not provide targeted case management services.
- The county stops providing targeted case management services without notifying the Division of Mental Health and Developmental Disabilities of the intent to discontinue providing targeted case management services.

Communications with Counties

Legal reference: 441 IAC 24.2(8)

For counties subcontracting with the Department for Medicaid-funded targeted case management services, requested information regarding targeted case management consumers and services may be provided to the board of supervisors.

For counties contracting with the Department for Medicaid-funded targeted case management services, data regarding targeted case management consumers and services will be provided, except when providing the data would be in violation of state or federal law.

This is based on the existence of a subcontractual relationship between two providers required to comply with the confidentiality provisions in the targeted case management approval standards. As the subcontractual relationship applies to the board of supervisors as an approved provider, not to other county employees, only requests for information from a member of the board of supervisors are honored.

Either written or verbal information may be provided to county boards. When providing written information, securing a release of information is preferable.

When the board of supervisors of a county that subcontracts with the Department requests information regarding a targeted case management consumer, send or provide the information directly to the board.

Provide educational information to any local board or entity as outlined in the county or multi-county targeted case management contract. Submit data for use in planning to the county, consortium of counties, or the Division of Mental Health and Developmental Disabilities upon request.

Fiscal Administration

Legal reference: 441 IAC 24.2(7)

Fiscal administration policies for state agencies are set in Iowa Code Chapter 8, "Budget and Financial Control Act," and Chapter 11, "Auditors of State." Specific procedures are contained in the ***Budget Procedures Manual***, issued by the Department of Management, and the ***Iowa Financial Account System Users Manual*** issued by the Department of Revenue and Finance.

Audits for federal programs are conducted according to procedures issued by the U.S. Office of Management and Budget in Circular A-133, "Single Audit."

All expenditures are monitored by the Targeted Case Management Unit budget analyst.

When equipment and supplies are delivered, keep the invoices for audit purposes. The Targeted Case Management accountant maintains records to establish an audit trail from monthly financial status reports. Notify the accountant if any equipment or supplies are erroneously billed to the Targeted Case Management Unit.

Liability

Legal reference: Iowa Code Chapter 669

As a state agency, the Department of Human Services is governed by the State Tort Claims Act, which states in part:

> "The state shall defend any employee, and shall indemnify and hold harmless an employee against any claim.....including claims arising under the Constitution, statutes or rules of the United States or any state. The duty to indemnify and hold harmless shall not apply and the state shall be entitled to restitution from an employee if, in an action commenced by the state against the employee, it is determined that the conduct of the employee upon which a tort claim or demand was based constituted a willful and wanton act or omission or malfeasance in office."

The State Tort Claims Act provides professional liability insurance for employees of the Department, including those involved in targeted case management. Tort claims are processed by the Iowa Attorney General's office.

If you become aware that a tort claim has been filed or may be filed, inform your immediate supervisor. The supervisor must ensure that appropriate administrative personnel, including the regional administrator, are informed of the pending action.

Organizational Plan

Legal reference: 441 IAC 24.2(6), 24.2(8) (225C)

At least every three years, an organizational plan for the unit will be written which:

- Reviews previous performance.
- Establishes future needs.
- Includes the unit's vision and mission statements.
- Describes the goals and objectives for providing targeted case management.
- Delineates coordination of consumer services.
- Identifies and minimizes barriers to consumers utilizing targeted case management.
- Summarizes program evaluation findings and continuous quality improvement processes.

Provide copies to the MH/MR/DD/BI planning councils for all counties served by the Unit to assist them in future planning and system development.

Program Evaluation

Legal reference: 441 IAC 24.2(6), 24.2(7), 24.2(8) (225C)

The Department of Human Services Targeted Case Management Unit conducts an annual evaluation of the effectiveness and efficiency of the services provided by the unit. The Targeted Case Management Unit surveys the satisfaction of the consumers and guardians receiving services and county boards of supervisors contracting with the unit. The results are summarized, shared with the advisory board, and used as the basis to modify service provision.

Continuous Quality Improvement

Legal reference: 441 IAC 24.2(6), 24.2(7), 24.2(8) (225C)

The Targeted Case Management Unit annually evaluates the effectiveness and scope of the unit's process, and makes revisions when necessary. The results of this evaluation, a summary of continuous quality improvement activities and information are communicated to all unit staff, and reflected in the organizational plan.

Methods for obtaining this information include but are not limited to educational information and meetings with leaders and members of various community and consumer groups. Opportunities for feedback are encouraged on an ongoing basis. Tools available for evaluation include reengineering, continuous quality improvement, advisory board review, and special committees.

Accreditation

Legal reference: 441 IAC 24.4(1), 24.4(3), 24.4(7) and 24.4(8) (225C)

The administrative unit applies for renewal of accreditation by the Mental Health and Developmental Disabilities Commission on form 470-3005, *Application for Accreditation*, at least 90 calendar days before the current accreditation expires. The information delineated in 441 IAC 24.4(7) accompanies the application.

Complaints

Legal reference: 441 IAC 24.6(225C)

Any person who believes that the Department is not delivering individual targeted case management services in accordance with the standards may file a complaint with the Division of Mental Health and Developmental Disabilities stating the nature of the problem.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

June 27, 1995

GENERAL LETTER NO. 13-H-12

ISSUED BY: Case Management Unit, Division of Policy Coordination

SUBJECT: Employees' Manual, Title 13, Chapter H, "Case Management Services," Title page, revised; Contents, pages 1 and 2, revised; and page 3, new; and pages 1 through 62, revised.

Summary

This chapter has been rewritten in the revised manual format and includes revisions to comply with changes in the requirements of 441 IAC, Chapter 24. Changes include revisions in the individual program planning process, narrative contents, administrative practices, consumer rights and interactions with the MHAP contractor.

Effective Date

July 1, 1995

Material Superseded

Remove from the Employees' Manual, Title XIII, Chapter H, "Case Management Services," and destroy:

Page	Date
Title page	April 30, 1991
Contents, pages 1 & 2	July 21, 1992
Manual Letter XII-H-3	February 2, 1993
1-9	April 30, 1991
10, 10a	July 20, 1993
11-17	April 30, 1991
18-21	May 17, 1994
22, 23	July 21, 1992
24	July 20, 1993
25	October 5, 1993
26	July 20, 1993

27, 28	April 30, 1991
29	July 21, 1992
30, 30a, 31, 32	October 5, 1993
33, 34	July 21, 1992
35	July 20, 1993
36, 36a	July 21, 1992
37	July 20, 1993
38	July 21, 1992
39, 40	May 17, 1994
41	July 20, 1993
42, 42a	October 5, 1993
43	July 20, 1993
44	April 30, 1991
45	October 5, 1993
46	July 21, 1992
47	July 20, 1993
48, 48a	October 5, 1993
49	April 30, 1991
50	July 21, 1992
51, 52	April 30, 1991
53-58	October 5, 1993
59-60	May 12, 1992
61	July 20, 1993
62-65	May 12, 1992

Additional Information

If you have any questions concerning this material, please contact the case management unit.

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

July 27, 1999

GENERAL LETTER NO. 13-H-13

ISSUED BY: Targeted Case Management Unit, Division of Policy Coordination

SUBJECT: Employees' Manual, Title 13, Chapter H, ***Targeted Case Management Services***, Title page, revised; Contents (pages 1 and 2), revised; and pages 1 through 58, revised.

Summary

This chapter is revised to incorporate the May 1, 1997, changes to the standards for state accreditation of case management service providers in Iowa Administrative Code Chapter 24. Additional changes are included based on the DHS Case Management Reengineering recommendations.

The organization of this chapter is revised, placing **Eligibility**, **Service Delivery** and **Records** sections at the beginning. Changes in these sections include replacing the *Individual Program Planning Documents* (470-2560) with the *Outcomes Achievement Plan* (renamed 470-2560), *Assessment Summary* (470-2446) and the *Assessment Worksheet* (470-3447). The *Quarterly Review* (470-2561) is revised and renamed *Case Management Service Activities Benchmark.* Instruction how to complete these forms is found in 13-H-Appendix.

Additional changes include:

- The **Chapter Overview** section is revised to update the list of requirements, due to the various forms changes.
- The **Eligibility** section revisions include:
  - Policy that includes the CPC application as the application for case management services, in certain instances.
  - Chapter 24 definitions of mental retardation, persons with chronic mental illness, and persons with developmental disabilities.
- The **Service Delivery** section revisions include:
  - Changes in the intake and evaluation section to incorporate the new *Assessment Worksheet* (470-3447).
  - Clarification of procedures when coordinating HCBS waiver services.

- Changes in the service planning documents. The *Assessment Worksheet,* 470-3447; *Assessment Summary,* 470-3446; and *Outcomes Achievement Plan,* 470-2560, are designed to flow and build on one another to result in a well-planned service plan to be implemented by the interdisciplinary team. This will lead to the achievement of consumer outcomes.
- The *Assessment Worksheet,* 470-3447, is used to assess consumer needs in the areas of health, safety, stability and self-sufficiency. This tool will also assist in assessing the need for services. Progress can be measured from year to year in each of the outcomes areas.
- The *Assessment Summary,* 470-3446, is then completed. With this form, the case manager summarizes the results (current functioning and needs for services) from the *Assessment Worksheet,* 470-3447. The *Assessment Summary* also documents consumer demographic information and historical information regarding the consumers life.
- The *Outcomes Achievement Plan* (OAP), 470-2560, is then developed by the interdisciplinary team. This is used to document the consumer's comprehensive plan, which is based on strengths, needs and consumer wants identified in the *Assessment Summary,* 470-3446.

♦ The **Records** section is revised to:

- Clarify the information and forms that must be contained in the case record.
- Incorporate optional weekly summary format for narrative.
- Eliminate requirement of signing and dating each narrative entry. Case managers will now initial the bottom of each printed page of narrative.
- Eliminate the required narrative heading "Discharge Summary."
- Eliminate the requirement to initial incoming correspondence.

♦ The **Administration** section is revised to:

- Include Chapter 24 changes to staff qualifications and duties, orientation and training, and workload ratios.
- Clarify the Department's responsibility when a county defaults the decision to provide case management services.
- Remove the detail of the procedures followed by the Division of MH/DD in accrediting providers. That detail is not necessary in this manual.

Effective Date

Immediately

Material Superseded

Remove the entire Chapter H, from Employees' Manual, Title 13, and destroy it. This includes the Title page, Contents (pages 1 and 2), and pages 1 through 62, all dated June 27, 1995.

Additional Information

Refer questions about this general letter to your supervisor.